



Parents and Students,

Thank you so much for registering for our first ever Summer Arts Camp. Here are a few details you need to know. First, all students must bring a lunch each day of camp. Please avoid packing a lunch containing nuts as other children may have allergies. Second, students need to be prompt each morning. Pick up and dismissal should happen in the lot between the PAC and church. Students will never be released from any other door. Students will have warm-ups and a gathering assembly every morning right at 8:00am. So they need to be in the door by 8:00am. Doors will open each morning at 7:45am.

On Friday, June 25th at 1:15pm. there will be a student showcase where students can show off their talents and what we have learned throughout the week. Please feel free to come and bring a visitor to the showcase. It will last till 1:45pm.

Your fee of \$150.00 is due at the time of registration. Registration closes on June. 1st. If you have any questions feel free to email me at jsamudio@stcharles.kettering.org or call (937) 434-4933. Please return your registration packet and fee to the St. Charles school office.

Musically yours,

Jeremy Samudio
Artistic Director



St. Charles Borromeo Catholic School
4600 Ackerman Blvd.
Kettering, Ohio

Student Name: _____ Age: _____

Guardian Name: _____ Phone: _____

Email: _____

Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

What kinds of arts experiences has your child been a part of?

***** For school office use only *****

Payment method: (please check one)

Cash _____

Paid in full: _____

Check _____

Accepted by: _____

STUDENT NAME _____
(Please print) Last First Middle Initial Date of Birth

St. Charles Borromeo School * 4600 Ackerman Blvd * Kettering, OH * 45429 * 937-434-3944 * Fax 937-434-6692

EMERGENCY MEDICAL AUTHORIZATION and TRANSPORT AUTHORIZATION FORM

(Ohio Revised Code 3313.712 and 3301-37-08. This is an ANNUAL state requirement)

Student Address _____ City _____ Zip _____

Home Phone _____ Grade _____ Teacher _____

Child Lives With (circle one) Mother/Father, Mother only, Father only, other (explain) _____

Legal Guardian (first and last name) _____

Mother's Name _____ Day/Work Phone _____ Cell _____

Address _____ Email _____

Father's Name _____ Day/Work Phone _____ Cell _____

Address _____ Email _____

Emergency Contacts (if unable to contact parents) / **Authorized Release** (parent authorizes person to pick up student)

****Must list at least 2 in the event parents cannot be located - list 2 non parental contacts****

Mother authorized to pick up student? YES NO Father authorized to pick up student? YES NO

Name	Relationship	Home Phone	Day/Cell Phone	Address
1)				
2)				
3)				

Instructions – parent/guardian to complete & return to school within **10 days of receipt**. **COMPLETE PART I or PART II – NOT BOTH**

Purpose – to enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. This information will be shared, as necessary, with teachers, administrative staff, health personnel and other school personnel.

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Medical Specialist _____ Phone _____

Local Hospital _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian _____

Date _____

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____

Date _____

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STUDENT NAME _____ Male/Female (circle one)

(Please print)

Last

First

Middle Initial

Gender

ANNUAL MEDICAL UPDATE

Instructions – please complete the health questionnaire below regarding your child. It is EXTREMELY important that you provide any pertinent medical history or information about existing conditions that may affect your child at school. The information will be reviewed by the school nurse and shared with school personnel as necessary. Homeroom teachers will receive a copy of this form for events that occur off school property (field trips or other such events).

1. Does your child have any allergies (food, insects, medicine)? YES NO If yes, describe:

2. Will your child require medications at school? YES NO If yes, describe and complete Request for Dispensing Prescription/Nonprescription Medication at School found on Option-C File Library.

3. Will your child require a health care plan or emergency health plan at school?
YES NO If yes, describe:

4. Please review the conditions below and circle YES or NO as it applies to your child.

Chronic health concern(s)	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Heart/cardiac disease	YES	NO
Seasonal allergies	YES	NO	Seizure disorder	YES	NO
Anaphylaxis	YES	NO	Cancer or history of cancer	YES	NO
Bleeding disorder(s)	YES	NO	Recent surgery, serious illness, disease	YES	NO
Fears/anxiety	YES	NO	ADHD/ADD	YES	NO
Vision concern(s)	YES	NO	Wear glasses or contacts (circle one if yes)	YES	NO
Hearing concern(s)	YES	NO	Wears hearing aid(s)	YES	NO
Speech delay	YES	NO	Learning delay/concerns	YES	NO
Use of walking device (crutches, wheel chair, walker)	YES	NO	Use of a prosthesis	YES	NO

If you answered YES to any of the questions above, please explain: _____

If there are any other health related issues that you feel that the school needs to be made aware of, please explain: _____

Signature of Parent/Guardian

Date